Accreditation's role in reducing medical errors

Accreditors can provide some leadership, but they can't do it on their own

Dennis S O'Leary
President
Joint Commission on Accreditation of Healthcare Organizations

Correspondence to:
Dr O'Leary
Joint Commission on Accreditation of Healthcare Organizations
1 Renaissance Blvd
Oakbrooke Terrace, IL 60181-4294

West J Med
2000;172:357-358

The admonition "First, do no harm," paraphrased from the Hippocratic oath,[1] has long been a guiding principle for the practice of medicine and the delivery of health care services around the world. But harm is done every day in health care. This has been well documented in the medical literature.[2] Now public awareness of medical errors and unexpected adverse patient outcomes is growing.[3] We have a serious problem, and it cries for timely, effective solutions. No one feels this more keenly than practicing physicians, health care executives, and the overseers of health care quality. Effective solutions, however, are proving to be a daunting challenge.

The oversight of health care quality in the United States is accomplished both through professionally based accrediting bodies in the private sector and through federal and state regulatory agencies. Many variations of this framework are now increasingly in evidence throughout the world. The initial model for external quality oversight in the United States was created by physicians in 1917. The resulting hospital standardization program of the American College of Surgeons was the forerunner in the United States of both the national Joint Commission on Accreditation of Healthcare Organizations and the federal and state regulatory framework now in place for all types of health care organizations.[4]

While these parallel oversight mechanisms are potentially duplicative, regulatory agencies commonly defer to accrediting bodies that meet their performance criteria. Although couched in the language of continuous quality improvement, the accreditation process is, at its core, a risk reduction activity. It begins with the setting of contemporary standards that address important organizational functions—for example, patient assessment, medication usage—and then encourages organizations, through the awarding of accreditation, to comply with these standards. The operating thesis is that if organizations are doing the "right things right," as reflected in the standards, then errors and adverse outcomes are less likely to happen than if there were no such standards. Notwithstanding the continued high frequency of errors, this thesis is almost certainly correct.[5] We are simply at a more primitive stage than we would like to be in our knowledge of why what happens happens in health care organizations.

It has become too easy to accept some (undefined) degree of medical errors as the inevitable by-product of today's increasingly complex patient care and simply to blame and punish individual caregivers when things go seriously wrong. Leaders of the medical profession and of health care organizations do not include reducing medical errors among their top priorities. Therefore, the level of commitment to analyzing relationships between errors and adverse outcomes on the one hand and organizational systems and processes on the other has so far been modest. There is now a growing urgency to undertake such analyses, to assimilate and share the knowledge gleaned, and then to use that information to design and redesign safer organizational infrastructures that minimize the potential impact of human factors in the delivery of care.[6]

Changing existing attitudes, behaviors, and priorities toward the identification and management of medical errors lies well beyond the "control" of accrediting bodies or regulatory agencies. Nevertheless, because of their roles as agents of public accountability, such oversight bodies for external quality do have the ability to foster constructive change in health care organizations. For example, largely through a voluntary self-reporting system, the Joint Commission on Accreditation of Healthcare Organizations has developed a database of serious adverse events and of the results of organizational analyses of these events. We periodically share the lessons learned with all accredited organizations.[7]

This simple effort to translate negative results into use-

ful information that can prevent errors in multiple settings is easily replicable anywhere in the world. Mandatory reporting of these occurrences and related analyses would rapidly produce an even richer database, but without the guarantee of confidentiality for the analyses (which does not currently exist), the evidence suggests[8] that the analyses would probably not be performed with the desired degree of thoroughness. The joint commission has also recently introduced the requirement that each accredited organization should establish reporting channels for unexpected adverse occurrences, perform an in-depth analysis of each such occurrence, implement improvements, and assess the impact of the improvements on internal systems and processes. This requirement should move error and adverse event management up leaders' lists of priority and help accredited organizations begin to learn more about themselves.

In the end, however, what we most need is a characteristic not described by Hippocrates—the ability of care givers to admit and accept fallibility. Furthermore, the organizations in which care is provided must create environments in which it is "safe" to admit error and safe as well to explore why the error occurred. In a sense, we need to extend the peer review collegiality inherent in the classic morbidity and mortality conference to the context of the entire organization. Simply stated, if we truly expect to improve the safety of patient care, those who directly provide the care must engage in the improvement process and feel safe in doing so.

References

1. Edelstein L. *The Hippocratic Oath. Supplements to the Bulletin of the History of Medicine.* Baltimore: Johns Hopkins University Press, 1943.
2. Berwick DM, Leape LL. Reducing errors in medicine. *BMJ* 1999;319:136-137.
3. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human. Building A Safer Health System.* Washington, DC: National Academy Press, 1999.
4. Roberts JS, Coale JG, Redman RR. A history of the Joint Commission on Accreditation of Hospitals. *JAMA* 1987;258:936-940.
5. Joint Commission on Accreditation of Healthcare Organizations. *The Measurement Mandate.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 1993.
6. Phillips DF. "New look" reflects changing style of patient safety enhancement. *JAMA* 1999;281:217-219.
7. Joint Commission on Accreditation of Healthcare Organizations. *Sentinel Event Alert 1998-2000.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2000.
8 O'Leary DS. Organizational evaluation and a culture of safety. *Proceedings of Enhancing Patient Safety and Reducing Errors in Health Care.* Chicago: National Patient Safety Foundation, 1999.